COMMENTARY

Gender, Place and Mental Health

by Margaret Haworth-Brockman and Jayne Melville Whyte

In 2006, the Standing Senate Committee on Social Affairs, Science and Technology, – led by Senators Michael Kirby and Joseph Keon – issued a report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*,[1] which extensively documented the imperative and potential directions for meaningful change in Canada's mental health services. While the report is undoubtedly important for focusing attention on mental health, there has been criticism of its lack of attention to gender.[a] For example, while the report contains stories by women and some discussion of specific issues, such as criminalized women[b] and Fetal Alcohol Syndrome/Effect, there is no systematic analysis of the different needs and experiences of women and men with regard to mental health issues.

On behalf of Prairie Women's Health Centre of Excellence, Jayne Melville Whyte, with assistance from Joanne Havelock, reviewed the Senate Report.[c] Their analysis from the perspective of rural Saskatchewan demonstrates how gender and place – the location of residence – are crucial components of understanding and responding to the mental health issues of women.

Distance and transportation difficulties in accessing mental health services can prevent rural women from receiving the care they seek. Melville Whyte agrees with the Senate Report recommendations for an increased number of integrated community-based services and she points out the importance of ensuring that services are provided locally in rural areas. Yet, she notes that the limited privacy in small communities may prevent women and men from using local support services. The Senate report does recognize the need to eliminate the stigma associated with mental illness. Melville Whyte recommends that tele-health and phone support lines can be an effective complement to local services. She notes that more attention should have been paid in the Senate Report to the role of

a See Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. Women, mental health, mental illness and addiction in Canada: an overview [Internet]. 2006 [cited 2009 Jan 14]. Available from www.cwhn.ca/PDF/womenMentalHealth.pdf

b The term "criminalized women" is now used by many feminists to "emphasize the social, economic, political, 'psy-entific,' and cultural processes which underpin the labelling of women as 'offenders'." See Maidment MR. "We're not all that criminal:" getting beyond the pathologizing and individualizing of women's crime. Women Ther. 2006; 29(3/4)z; 35-56, p. 40.

c This discussion is summarized from Melville Whyte J, Havelock J. Rural and remote women and the Kirby-Keon report on mental health: a preliminary gender-place analysis. Winnipeg: Prairie Women's Health Centre of Excellence; 2007.

In part, the differences can be attributed to the fact that Aboriginal people are over-represented in high risk groups, such as injecting drug users, sex trade workers and prisoners. Aboriginal women are more than twice as likely to be living in poverty as their non-Aboriginal counterparts and they are more likely to be exposed to substance use and frequent domestic violence. Aboriginal women also experience discrimination, both within their own communities and in dealing with non-Aboriginal health services.[7]

In many ways, the experiences of women and girls in Canada, particularly those from marginalized populations, mirror those of women and girls around the world, in developing and developed countries:

> … while women in Canada may not suffer the extremes of subordination faced by many of their counterparts in other parts of the world, inequality and violations of women's human rights still contribute to their vulnerability and to the challenges they face in seeking treatment for HIV/AIDS. As in other parts of world, women living in poverty, women who inject drugs, Aboriginal women, women in the sex trade, and many women who come from countries where HIV is endemic are particularly vulnerable to HIV/AIDS…[8,pi]

Engendering the Response to HIV/AIDS

Given all these facts, it might seem reasonable to expect that the Canadian government and international agencies would already have devised gender-appropriate strategies and interventions for prevention, care, treatment and support. Indeed, there is increasing high-level acknowledgement of the role of sex and gender in the pandemic. Many efforts have been and are being made to develop prevention methods for women and girls, including the female condom and microbicides. Educational and informational programs for women and men, girls and boys are also common in many countries around the world, including Canada. Nevertheless, the numbers of people

– especially women and girls – living with and dying from HIV continue to rise. The time has come to revisit and re-evaluate national policies and international guidelines using a gender lens.

In recent years, both UNAIDS and World Health Organization, seen as leaders on HIV/AIDS, have developed publications and recommendations that now include attention to gender as well as to women and girls. A significant exception, in our opinion, is the advice for effective HIV prevention in ***low-incidence*** countries. UNAIDS and WHO differentiate between the responses needed in low-incidence countries and those needed in high-incidence countries (referred to as "generalized epidemic states"). A recent UNAIDS report on HIV prevention reads that:

> An understanding of the nature, dynamics and characteristics of local epidemics is needed to ensure that HIV prevention strategies can be reviewed and adapted to fit local conditions. **In low and concentrated HIV prevalence settings where the epidemic is nascent, attention needs to be given to prioritizing HIV prevention among those at highest risk, identified after epidemiological and social mapping.** In generalized HIV epidemics, strategies for such populations combined with broader strategies to reach all segments of society at sufficient scale.[9,p19] [emphasis added]

While targeted responses are excellent in theory, the history of HIV suggests that focused efforts have not only failed to stem the tide of the pandemic, but have actually contributed to the spread of HIV among those already at greatest risk – women and girls. A comparison of the history of the epidemic in Canada and South Africa underscores the hazards of adopting a targeted approach to HIV/AIDS.

family violence as well as sexual and other abuse, as a cause of mental health issues for girls and women. Better training for rural police forces in understanding and handling mental health crises would also be beneficial. Overall, Melville Whyte emphasizes that we must address the underlying causes of stress and poor health for rural and remote women: the farm economy, poverty, Aboriginal issues, family violence, balancing work-family-community responsibilities and the need for inter-generational connections and cross-cultural understanding. She also highlights the value of involving rural and remote women in planning processes.

In the final analysis, place and gender play critical roles in mental health. Our response to the mental health needs of women and men living in Canada must include these factors if we hope to create effective and appropriate policies and programs.

References

1. Kirby M, Keon W. Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada [final report]. Ottawa: Standing Senate Committee on Social Affairs, Science and Technology; 2006.